CS-1773
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State of Michigan
Department of Civil Service
EMPLOYEE BENEFITS DIVISION
400 South Pine Street, P.O. Box 30002
Lansing, Michigan 48909

MEDICAL CARE SPENDING ACCOUNT ENROLLMENT FORM

Instructions: Complete this form to enroll in the Medical Care Spending Account for the current calendar year. Sign and date the form, retain a copy for your records, and mail the completed form to the address above. **Midyear enrollment must occur within 30 days of the qualifying event; e.g., family status change, and be submitted with supporting documentation.**

EMPLOYEE INFORMATION

PLEASE PRINT OR TYPE

Name			**Effective Date (Civil Service Use Only)**
Home Address			**Work Phone** **Ext.**
City	**State**	**Zip Code**	**Home Phone**
Social Security Number		**Employee ID Number**	

AUTHORIZED DEDUCTIONS

Calculate only the amount needed to cover your medical care expenses for services provided during the calendar year from January 1 to December 31.

Biweekly Amount	Times	Pay Periods (1 to 26)	Equals	Annual Amount
$	X		=	$

The biweekly deduction amount times the number of pay periods cannot exceed an annual amount of $5,000.

I authorize the State of Michigan to reduce my gross biweekly salary in the amount specified. I understand I am making a binding election for the entire plan year and authorize the State of Michigan to adjust my pay accordingly.

I certify that I have read the Flexible Spending Account Booklet and I understand:

1) *that my gross salary will be reduced every regular pay period for the number of pay periods I specify and by the amount I specify on this Medical Care Spending Account Enrollment Form.*
2) *that it is my responsibility to make sure that the deduction specified on this Enrollment Form is accurate, and I understand that errors cannot be corrected beyond the date specified on my Confirmation Statement.*
3) *that my Medical Care Spending Account must be used only for IRS approved medical care expenses incurred during the calendar year (or during that portion of the year for which I am eligible).*
4) *that my biweekly deduction may not be stopped or changed during the year except in the case of an IRS approved change in "family status."*
5) ***that any amount remaining in my Medical Care Spending Account after timely claims have been submitted, must be forfeited.***

I certify that:

1) *I understand the rules governing contributions and reimbursements, as described in the Flexible Spending Accounts Booklet.*
2) *The information provided on this form is true and complete.*

I agree and understand that any misstatement or falsification of material facts will result in my removal from the Medical Care Spending Account, may cause an IRS and/or state audit with possible additional tax, interest, and penalties; may result in civil and/or criminal prosecution; and may jeopardize my employment status with the State of Michigan.

Employee's Signature	**Date**